Claim Analysis
2/9/14

Sample: Claimant's Name Redacted
Employer Name Redacted
1596 pages

Date of Hire: 1/1/01

Date of Injury: 1/12/10

Claim Number:
SCA ___________

pres.

Status: Open

Occup: Pre-School Teacher

Claims reps involved in claim:

Name	From	To
Sunny S.	1/19/10	1/24/10
Jesse S.	1/25/10	5/26/10
NCM S C.	3/5/10	10/13/10
JB.	5/27/10	1/9/11
R V. NCM	10/14/10	2/1/11
Cl Ex 4.		1/10/11

TOTAL CL. EX: 4

TOTAL NCM: 2

Duration: 1/12/10 - present
4 years and 1 month; still not cLsed.

SUMMARY OF CONCLUSIONS:

1. All amounts paid here above $83,236.33 are the result of the claims mishandling, claims negligence, nursing negligence, and legal negligence of Insurer and its nurse case managers and attorneys.

2. The diagnosis of CRPS was never supported by diagnostic tests, necessary findings on physical examination, or results of sub rosa. Therefore, all payments relating to CRPS are incorrect.

3. Claims Department and Def Attorney never showed the sub rosa films to AME Dr. N. Those films show Clmt able to do activities which she indicated she could not. This is claims and legal malpractice.

4. There were 20 "red flags" on this case which were not attended to by Insurer.

5. Agreement to AME N. was claims and legal malpractice as the AME was not in the correct medical specialty for CRPS and any experienced practitioner in work comp in California would have known by 2011/2012 that all AME's "split the baby in half" and that the AME would have produced a worse result that that from the PQME, Dr. M. As a result of this, many claims professionals and defense attorneys stopped using AME's in 2010, 2011, and 2012. This should have been the policy followed by Insurer. It may be the policy Insurer and Def Atty are following re proposal for psych AME as they are apparently relying on PQME F rather than agreeing to an AME.

6. Claims Examiner Cl Ex 4. made inadequate efforts to settle this case with Claimant prior to her retention of an attorney. These inadequate efforts have resulted in the escalation of this claim and retention by Applicant of counsel. Cl. Examiner Cl Ex 4. "Low balled" the Claimant in proposing settlement and failed to follow up with her in an effort to resolve the case prior to her retention of counsel.

7. The Claims Examiner had inadequate knowledge of the AMA *Guides* to determine if the ratings herein were correct. This is claims

malpractice. Despite that, Claims Examiner produced significant delays in referring the report of AME N. to Iratings for an expert rating and never forwarded the report of PQME M for expert rating.

PROPOSAL FOR RESOLUTION:

1. **Insurer stipulates that the total of payments due which relate to EMPLOYER's responsibility for the injury of 1/12/10 is $83,236.33.**

2. **Insurer shall report to the WCIRB that the payments should be amended to reflect the calculations noted below as to TD, PD, Past Medical, Future Medical, Supp. Job Displacement Benefit, and amt. to settle noted above.**

3. **Insurer agrees that the amount of increase in EMPLOYER's experience modification rate above $83,236.33 is due to Insurer's handling of this claim and not attributable to EMPLOYER.**

4. **Insurer agrees to reimburse EMPLOYER for the amount of its work comp premium which was due to the increase in its experience modification rate attrib to Insurer's handling of this claim. To that end, the parties agree that EMPLOYER's premium for 2010-2011-2012-2013-2014 should have been calculated based upon EMPLOYER's x-mod in 2009-10 of 106.**

Claim Review Criteria:		**No. of Errors:**
Timeliness	***NO***	**9**
Coverage	***OK***	**0**

Investigation	***NO***	**44**
Evaluation	***NO***	**20**
Reserving	***NO***	**5**
Litigation Management	***NO***	**18**
Medical Management	***NO***	**29**
Documentation/Reporting	***OK***	**1**
Settlement/Negotiations	***NO***	**10**
Recovery	***Not Applicable***	
Fraud	***NO***	**0**
Management and Supervisory Controls/systems	***NO***	**14**
File Maintenance	***OK***	**0**
Diary	***OK***	**0**
Taking of Action	***NO***	**12**

Primary Adjusting Failures

TOTAL ERRORS: **83 in 10 different categories**

INCLUDES CLAIMS MALPRACTICE

INCLUDES NURSING MALPRACTICE

INCLUDES LEGAL MALPRACTICE

RED FLAGS:

1. 4/15/10: CRPS Diagnosis [Note: not supported by diagnostic tests including bone scan and x-ray]

2. 4/16/10: Bone scan, the "gold standard" for diagnosis of CRPS does not show CRPS.

3. 5/26/10: Clmt. dtr advises Clmt. being seen at Drs. G. by Physician's Asst., "Dr. P.A.," for Potential CRPS diagnosis, not by doctor.

4. 5/26/10: Claimant speaks Bosnian or Croatian. Is refugee from Bosnia. [High incidence of work comp claims amongst this population.]

5. 5/27/10 Clmt's dtr doing internet research on CRPS.

6. 5/27/10 Clmt dtr emailing NCM asking for med tmt immediately

7. 5/27/10 Clmt dtr getting advice from physician in Bosnia on treatment

8. 5/27/10 Clmt. dtr writes NCM indicating that Dr. C has offered his help, has treated these patients, and has been named one of the top doctors of the year in the Bay Area a couple of times. NCM resists because Dr. C is not in MPN.

9. 5/27/10 Clmt's dtr now wants Dr. M **whom she found online**

10. 5/27/10 Clmts dtr feels her mother was left without care for 5

months due to the doctor's irresponsibility.

11.	6/4/10	Clmt's dtr advises NCM she chooses Dr. M based on her online research. Clmt's dtr is clearly managing the case based on her online research.
12.	6/29/10	Dtr. wants pool therapy as she has read about it on internet. Not prescribed by any doctor.
13.	6/30/10	EE tells Physical Therapist that dr. was irresponsible and that she was "left to suffer."
14.	3/15/11	AA is W. W. Known for 100% cases.
15.	3/31/11	Dr. M indicates Clmt needs Functional Restoration program and that this is a "catastrophic claim."
16.	7/28/11	Pt. has now failed 4 types of treatment, and Dr. M wants multidisciplinary eval.
17.	8/21/12	Clmt. begins receiving SSDI benefits (Social Security Disability). This is a red flag for a 100% case.
18.	4/16/13	Dr. L reviewed portion of med records and will not accept Clmt. as patient. Red Flag: Phys refuses to take Clmt.
19.	10/16/13	AA expresses interest in *Ogilvie*. Red flag for 100% case.
20.	3/31/11	Clmt would not undergo sympathetic blocks. Usually, people who really have this condition are willing to undergo the treatment.

PENALTY EXPOSURE: All the responsibility of Insurer as detailed below.

1. 5/31/10 SIP OF 10% OF $101.67 FOR LATE PAYMENT OF TTD OF $1,016.74

2. 4/18/11 Cl. Ex. increases PD by 15% as Er cannot take EE back to work. PENALTY 2 EXPOSURE: THIS SHOULD HAVE BEEN DONE ON 3/22/11. IT IS DONE NEARLY 1 MONTH LATER. PENALTY EXPOSURE = 25% OF PD.

3. 10/4/12 AA writes: Per AME Dr. N. of 5/14/12, please pay TTD through 1/17/12.

   Note: If not done by 10/18/12, penalty exposure.

4. 10/5/12 AA requests auth for Lidoderm patches as AME Dr. N. said appropriate.

   Note: If not done by 10/19/12, penalty exposure.

5. 1/3/13 EXPEDITED HRG SET BY AA TO ADDRESS:

   1. Retro TD from last date paid (2/8/11) though 1/17/12 (P+S date by Dr. N.) **Apparently not paid.**

   3. Penalties 5: Req benefits be brought current on 10/4/12 with no response from Defendants.

6. 1/3/13 Penalties: Req benefits be brought current on 10/4/12 with no response from Defendants.

   1/3/13 STIPS ENTERED:

   1. TD: 2/9/11 - 1/10/12 FOR $1,638.50

   2. PMT TO EDD FROM 2/9/11 - 1/10/12

<u>Overpayment Summary</u>

1. Total Resp. of EMPLOYER: $83,236.33

2. Total resp. of Insurer:

a. Reserves above $83,236.33: 191,204.51

b. Pmts above $83,236.33: 55,893.18

All reserves and amounts paid above $83,236.33 should be the responsibility of Insurer due to errors, claims mal-practice and mishandling, nursing malpractice, and legal malpractice.

Total amts paid: (7/22/13)	**139,129.51**	
Less	**<u>83,236.33</u>**	
BALANCE:		**$55,893.18**

Total reserves: (7/22/13)	**$274,440.84**
Less	**<u>83,236.33</u>**
BALANCE:	**$191,204.51**

4/28/02 Clmt had fracture of Chest/Ribs while working for EMPLYER.

4/27/06 Drs. G. records show prior work comp injury involving

contusion to both hands. Handled by SCIF. Claim No.: 04786658. Impacted left hand on desk while carrying child at work. She was employed by EMPLOYER at this time. EE was changing a child's diaper. Child kicked Ee which caused her wrist to strike changing table.

Paid TTD from 4/28/06 - 6/2/06 = $2,437.05 and continue at $473.87 per wk based on earnings of $710.80 per week.

12/15/06 SCIF to close claim file on inj of 4/27/06.

1/12/10 Right foot sprain. Accepted. While walking down hallway she slipped and hurt right foot. **Please note: Injury to right ankle accepted but not CRPS as not diagnosed at this date.**

Reported to ER on that date.

Presented to Drs. G. on that date. Dx by PTP Dr. Kuuuu was right foot sprain. 6 visits of PT approved.

Findings: Comminuted fracture at right cuboid without significant displacement of any fracture fragments. (This was not picked up on x-ray but picked up on mri later, after which she was casted. MRI dated 2/18/10. See note of that date.)

Seen at Drs. G.. Prescribed Ibuprofen 600 mg oral. She was taken off work 1/13/10.

1/13/10 Clmt. seen again. **X-ray shows no fracture.** Dx: Right foot/ ankle sprain.

1/22/10 Clmt was walking down hallway to classroom. Just slipped and twisted her right foot. She just slipped. Witnesses saw it.

PT for right foot and right ankle x 6 authorized with Drs. G..

Clmt LDW on 1/12/10. Placed on TTd. Er unable to accomod mod duty as of 1/13/10.

Insd had no doubts about claim.

Clmt. indicates no pre-existing conditions.

Cyndi stated she checked the floor post injury. There was no water or object that would cause Clmt to fall.

RTW Mod (Stand/wlk 5 mins dur; 15 mins/hr, 4 hrs total. Sit down work only.)

INSD UNABLE TO ACCOMOD LT DUTY.

1/25/10 S Hwei, CFO at EMPLYER, expresses concern that Applicant
is not able to drive with cast on her right foot.

1/26/10 TTD @ 986.69.

Her wages are $1,538.03 per half month.

$1,538.03 x 24 = $36,912.72 divided by 52 wks = $709.86 /wk.

TTD rate would be: $473.24.

Ultimately, TTD paid at $508.37. This appears to be correct as there were varied earnings per 2 wk pay period.

[TTD from 1/13/10 - 2/7/11 @ $508.37/wk = 391 days @ 72.63 = $28,398.33.]

1/27/10 PT visit: Patient can walk but it is painful. Symptoms include intermittent pain with weight-bearing in right foot and ankle. Diffuse edema noted throughout entire right foot and ankle. Pronounced ecchymoses at the distal metatarsals 1-5. Palpable warmth. Tenderness noted over ATF ligaments.

Assessment: Right ankle sprain, contusion

2/1/10 C at insured advised No Mod Duty available.

2/4/10 Patient reports increased pain and especially swelling after PT exercises on 2/3/10.

2/11/10 Auth granted for MRI of Right ankle/foot by One Medical

2/18/10 **<u>MRI of right foot/ankle:</u>**

> **1. Comminuted fx of right cuboid without significant displacement of any fracture fragments.**

2/26/10 Dr. Kuuuu requests boot and referral to podiatry.

Dr. P. (Podiatrist) applies cast.

3/3/10 Clmt. treating with MPN Dr. Drs. G. Dr. Kuuuu.

Dr. Kuuuu diagnoses: Cuboid fracture confirmed on mri.

Short leg cast x 4 wks [until 4/3/10]

Then, PT for 6 wks. [until 5/17/10]

3/5/10 **<u>Cuboid fracture confirmed on mri.</u>** Tmt: Cast. Non-displaced fracture. After cast removed, PT.

3/16/10 **REDACTED INFO. APPEARS TO BE INFO FROM CLMT. NO BASIS FOR REDACTION. CLMT. APPARENTLY EXPRESSES DISAPPOINTMENT AND BITTERNESS REGARDING CLAIMS EXAMINER.**

3/27/10 Rel to Mod wk on 3/24/10:

1. Stand: 1 - 3 hrs
2. Walk: 1 - 3 hrs
3. Sit: 8 - 10 hrs

1. Stand/walk no more than 10 mins at a time; 30 mins per hour: Sit down work.

4/15/10 Dr. P. (podiatrist) indicates possible CRPS due to little improvement and continuing pain.

RED FLAG 1: CRPS DIAGNOSIS.

4/16/10 Employee allegedly had bone scan done.

BONE SCAN DID NOT SHOW RSD/CRPS.

ERROR 1: TMT FOR CRPS SHOULD NOT HAVE BEEN AUTHORIZED AS BONE SCAN DID NOT SUPPORT DIAGNOSIS. [Investigation, Eval., Medical Mgmt., Mgmt./Supervisory Controls]

PER DR. HADLER, *OCCUPATIONAL MUSCULSKELETAL DISORDERS,* BONE SCAN IS THE GOLD STANDARD FOR DIAGNOSIS OF THIS CONDITION.

ERROR 2: As the attached article shows (attached to end of this Claims Analysis), the following are necessary for diagnosis of CRPS. [Investigation, Eval., Medical Malpractice, Mgmt/Superv Control]

1. **Temperature difference measured by infrared thermometer or infrared thermal imaging.**

The assessment of temperature side differences in complex regional pain syndrome is mandatory for establishing the diagnosis and can be detected with an infrared thermometer at different measuring points or with infrared thermal imaging. However, the dynamic character of this phenomenon (depending on disease duration and environmental factors) should be taken into account.

While in healthy patients only slight differences in skin temperature between sides have been documented (hands, 0.24±0.23°C; fingers, 0.43±0.26°C), in patients after hand or wrist trauma without any complication side differences of

0.9°C±0.8°C were reported up to 8 weeks after trauma.[9,10] In patients with complex regional pain syndrome, side-to-side temperature differences of 0.5°C, 0.6°C, or 1°C have been observed indicating high statistical variation and substantial overlap with trauma patients lacking complex regional pain syndrome: **a useful diagnostic threshold should be set at a side difference of 1.5°C to differentiate between normal physioLgical post-traumatic states and complex regional pain syndrome I.[11-13]**

THEREFORE, THERE SHOULD HAVE BEEN A TEMPERATURE DIFFERENTIAL BETWEEN THE ANKLES OF AT LEAST 1.5 DEGREES CELSIUS SHOWN BY INFRARED THERMOMETER TO ESTABLISH THE DIAGNOSIS.4/20/10

2. Check should be made on erhthrocyte sedimentation ate, C-reactive protein, and leukocytes increased to see if the patient has inflammation from another cause.

For differential diagnosis, this important finding points out that in patients with symptoms of complex regional pain syndrome but increased findings of generalized inflammation (erythrocyte sedimentation rate, C-reactive protein, and leukocytes increased), other causes of inflammation should be excluded (Table 3).[21-23]

Differential diagnoses for CRPS include:

1. Soft tissue infection

2. Osteitis

3. **Fracture nonunion [this patient had a cuboid fracture; therefore, nonunion should have been examined] NOT DONE BY SUBSEQUENT MRI.**

   ERROR 3: No investigation of fracture nonunion by subsequent mri. [Investig, Eval, Med Mgmt, Mgmt/Superv Control]

4. Rheumatoid arthritis

5. Neurologic disorders (i.e. polyneuropathy, neuritis, etc.)

6. Malignant tumors

3. Conventional x-rays of both extermities are standard for diagnosing CRPS. X-ray of the affected extremity should show diffuse osteoporosis with a severe patchy demineralization, especially of the periarticular regions, conbined with subperiostal bone resorption. (Predictive value of demineralization findings was 83% 7 weeks after trauma for CRPS.)

Since Sudeck[27] described the typical radiographic changes on plain radiographs of the affected extremities, conventional bilateral radiographs of the hand are standard for diagnosing complex regional pain syndrome. The primary radiographic manifestations are diffuse osteoporosis with a severe patchy demineralization, especially of the periarticular regions, combined with a subperiostal bone resorption (Figure 2).

However, the article beLw leads to a conclusion that radiographic changes appear late during the course of the disease and that radiography does not qualify as a screening procedure.

4. Three-phase bone scans have been used for 3 decades to diagnose CRPS. The characteristic pattern of scintigraphic findings are: accelerated bLod fLw into the affected limb combined with an increased diffuse activity during the bLod pool phase and an increased periarticular uptake in the delayed static phase. These are supposed to be pathognomonic [(of a sign or symptom) specifically characteristic or indicative of a particular disease or condition.] **for complex regional pain syndrome.**

Todorovic establised a positive predictive value of 97% in delayed bone scintigrams.

Three-phase bone scans have been used for three decades to diagnose complex regional pain syndrome. In particular, Kozin et al[29,33,34] established the characteristic pattern of scintigraphic findings that are present in complex regional pain syndrome patients. Accelerated blood flow into the affected limb combined with an increased diffuse activity during the bLod pool phase and an increased periarticular uptake in the delayed static phase are supposed to be

pathognomonic for complex regional pain syndrome (Figure 3).

Todorovic et al[40] investigated complex regional pain syndrome patients after trauma using three-phase bone scan and radiography and found a high sensitivity with a positive predictive value of 97% in delayed bone scintigrams, whereas the radiography reached a sensitivity of 73% and a positive predictive value of 90%.

The authors of the attached study felt that three-phase bone scans were a good diagnostic tool in non-trauma patients. The authors did not feel that three-phase bone scans could differentiate between early normal post-traumatic states and CRPS.

SUMMARY: THE DIAGNOSIS OF CRPS SHOULD NOT HAVE BEEN MADE WITHOUT THE FOLLWING TESTS:

1. Thermal temperature measurement of extremities showing 1.5 C temp differential,

<u>NOT DONE HERE</u>

AND

2. Check of erhthrocyte sedimentation ate, C-reactive protein, and leukocytes increased to see if the patient has inflammation from another cause.

<u>NOT DONE HERE</u>

AND

3. X-rays of affected extremity (compared to non-injured extremity) showing:

a. Diffuse osteoporosis with a severe patchy demineralization combined with subperiostal bone resorption

are standard for diagnosing CRPS.

NOT DONE HERE

AND

4. **Three-phase bone scan of affected extremity accelerated blood flow into the affected limb combined with an increased diffuse activity during the blood pool phase and an increased periarticular uptake in the delayed static phase.**

BONE SCAN DONE. THESE FINDINGS NOT SHOWN.

ERRORS 4 AND 5: **As you will see, this was not established by either Dr. A. (error 4) or the Drs. G. podiatrist, Dr. P. (error 5), who raised the potential for a diagnosis of CRPS initially.**

[Investigation, Eval., Medical Management, Mgmt./Superv Control]

Admitted to Medical Facility .

Admission dx: Calcific tendonitis of shoulder.

Admitted: 1552

Dischg: 2359

Left shldr x-ray: Prom calcif adj to left humeral head with may represent calcific tendinitis or calcification within the bursa.

Patient noted that she had had left shoulder pain off/on for 1 yr. Prev shldr x-ray in 2009 indicated calcific tendinitis.

4/3/10 Patient should have come out of cast by this time. PT continues for next 6 wks, up until 5/17/10.

4/21/10 Patient seen at Drs. G. for follow-up after bone scan. "Dr. P. is clinically concerned about CRPS despite the negative bone scan. Dr. P. suggests that he patient be evaluated for CRPS by a pain specialist. Patient complains of persistent pain, hypersensitivity. The brushing of a blanket over her foot causes severe pain, cold temperatures worsen her symptoms. She is now wearing post-op shoe."

Right foot on PE: positive color changes in comparison with opposite foot [no rpt that it is either mottled or cyanotic--note, these could have caused by casting], positive edematous ankle, significant pain out of proportion to stimulus does not decrease with repeated stimulus, plus marked sensitivity to dorsum (top) of foot over tarsals over the 5th metatarsal and to posterior (back) ankle." **Note: No rpt of temperature differential.**

4/26/10 **BONE SCAN DONE**.

5/20/10: BONE SCAN NEGATIVE FOR TYPICAL RSD/CRPS. NOTE FROM NURSE S Q..

4/27/10 Auth given for right foot bone scan to rule out CRPS.

4/28/10 Drs. G. Admission/SC

1. DX: Left shoulder pain, pCl Ex 4able recurrent tendonitis/ bursitis.

2. PMH:

a. 1/28/10 Sprain/strain ankle

b. 7/13/09 Cerv intervertebral disc disorder with myelopathy

c. 6/15/09 Swelling, mass or lump in head or neck

3. EKG done on 4/18/10. Borderline.

4/30/10 Auth. given for pain mgmt consult.

5/19/10 Examiner phone call from One Call re bone scan. Informed that they received a call from Employee's daughter stating that ee already had bone scan. Order was voided.

5/19/10 3 PHASE SKELETAL SCINTIGRAPHY: TEST DATE 4/16/10.

FINDINGS DO NOT SHOW THE TYPICAL SCINTIGRAPHIC PATTERN FO RSD/CRPS.

5/19/10 Clmt. rel to mod duty on 5/19/10 with standing of 1 - 3 hrs, Walking 1 - 3 hrs, and Sitting 8 - 10 hrs. She was to stand/walk no more than 15 mins at a time, 30 mins/hr. She was to do sit down work.

MED TMT IS APPROPRIATE THROUGH 5/19/10. AFTER THAT, IT IS CAUSED BY NEGLIGENT CLAIMS HANDLING. INADEQUATE INVESTIGATION, MEDICAL MANAGEMENT, AND CLAIMS SUPERVISION. TESTS FOR DIAGNOSIS OF CRPS NOT DONE; BONE SCAN DID NOT SUPPORT DIAGNOSIS OF CRPS.

INSURER FAILED TO HANDLE THE CLAIM COMPETENTLY. THEREFORE, EMPLYER SHOULD NOT BE RESPONSIBLE FOR MED TMT AFTER 5/19/10.

5/20/10 Claim reassigned to Sr. Examiner. Clmt. diagnosed with CRPS. [As noted above, diagnosis not supported by necessary tests.]

5/21/10 **ERROR 6: CL. SUPERVISOR C LNU REFERS TO CL. EX. 3 TO DETERMINE IF THIS MEETS THE DIAGNOSTIC CRITERIA FOR CRPS. SHE FORWARDED PAGES IN THE GUIDES. IF SHE HAD REVIEWED THE PAGES, SHE WOULD HAVE SEEN THAT IT DOES NOT.**

C LNU SHOULD HAVE REVIEWED THE PAGES HERSELF AND DETERMINED IF THIS MET THE CRITERIA RATHER THAN LETTING AN INEXPERIENCED CLAIMS PERSON DO IT. [Investigation, Eval., Med Mgmt, Mgmt./Superv Controls.]

IT DOES NOT.

Upper Extremity chapter would have indicated you need 8 of the following for a dx of CRPS: (p. 496, Table 16-16)

Skin color: mottled or cyanotic (no rpt of mottled or cyanotic skin color in any medical report)

Skin temperature: cool (no rpt in any med rpt of skin temp cool)

Edema: this was listed in med rpts

Skin dry or overly moist: no rpt of this

Skin texture: smooth, nonelastic: no rpt.

Soft tissue atrophy: especially in fingertips: no rpt

Joint stiffness and decreased passive motion:
no rpt.

Nail changes: blemished, curved, talonlike:
no rpt

Hair growth changes: fall out, longer, finger: no rpt

X-ray changes: trophic bone changes, osteoporosis:
NOT SHOWN

Bone scan: Findings consistent with CRPS:
NOT SHOWN

THEREFORE, THE PATIENT WOULD NOT HAVE MET THE CRITERIA FOR DIAGNOSIS OF CRPS IN AN UPPER EXTREMITY BECAUSE PATIENT DID NOT HAVE 8 OF THESE.

LWER EXTREMITY CHAPTER DOES NOT INCLUDE THE "8 FINDINGS CONCURRENTLY FOR A DIAGNOSIS OF CRPS" NOTED ON P. 496.

<u>ERROR 7:</u> Cl. Examiner Cl. Ex. 3 misses this, and C LNU does not follow up. [I, E, MM, SC]

<u>ERROR 8: CL. EXAMINER CL. EX. 3 DOES NOT DO PLAN OF ACTION FOR 3 MONTHS, ON 8/26/10.</u> [Timeliness, Taking of Action]

This is negligent claims handling and negligent Claims Supervision.

<u>ERROR 9:</u> Supervisor does not follow up with this. [SC]

5/26/10 Clmt. requests referral to therapists who are familiar with

dealing with CRPS.

5/26/10 Clmt's daughter advises Cl. Examiner that Clmt never sees doctor but is only seen by Physicians Assistant, "Dr. P.A.."

RED FLAG 3: CLMT SHOULD BE SEEN BY DOCTOR, NOT PHYS. ASST.

PMT SHOULD NOT BE MADE FOR PHYSICIAN ASSISTANTS.

RED FLAG 4: CLMT SPEAKS BOSNIAN OR CROATIAN.

ERROR 10, 11: At this point, Cl. Ex. should have ensured Clmt being seen by a doctor. Cl. Superv should have followed upon on this. A clmt with alleged CRPS should NOT be seen by a Physician's Asst. [MM, SC]

5/26/10 Clmt's daughter indicates that Clmt. received all medications (Neurontin, Zantac, Prednisone, and Lidoderm--Ee unable to tolerate Neurontin due to side effects and has discontinued it.)

5/26/10 NCM Q. requests that Clmt be seen by dr, not PA.
GOOD.

5/27/10 **RED FLAG 5: CLMT'S DAUGHTER IS NOW DOING INTERNET RESEARCH ON CRPS.**

CLMT'S DTR ADVISES NCM THAT DR. P. (PODIATRIST) SAID THERE WAS NOTHING HE COULD PRESCRIBE.

RED FLAG 6: CLMT DTR IS NOW EMAILING NCM AND ASKING FOR MED TREATMENT IMMEDIATELY.

RED FLAG 7: CLMT'S DTR WRITES NCM:

"I also contacted a friend of mine who is by the way doctor--for work related injuries--Physical medicine and rehabilitation, in Croatia (Zagreb) and he told me that several specialists need to work together (orthopedist, neurologist, and physiatrist) in order to help with treatment. Dr. C would be our first choice.)

NCM now pushing Clmt to have treatment with Dr. A. because he is MPN, and Dr. C is not.

RED FLAG 8: CLMT'S DTR WRITES BACK TO NCM indicating that Dr. C has offered his help, has treated these patients, and has been named one of the top doctors of the year in the Bay Area a couple of times.

5/27/10 **NCM convinces Clmt and dtr to have Dr. A. as PTP. Auth. given.**

ERROR 12, 13: This is error because Dr. A. does not do correct tests for diagnosis of CRPS, and NCM fails to ensure he does them. [MM, MM]

5/27/10 NCM has conversation with Physical Therapist at Star PT.

ERROR 14, 15: Nurse Case Manager Q. tells Physical Therapist Clmt has CRPS. This is completely incorrect as the bone scan did not support the diagnosis.

We are now in nursing malpractice area. NCM is diagnosing CRPS when it is not supported by bone scan results. Further, she is repeating incorrect diagnosis without doing necessary investigation [and having tests done] to determine if diagnosis is correct. [MM, MM]

NURSING MALPRACTICE

NCM WRITES:

"Lengthy conversation with Fred, the therapist that EE is scheduled with for tomorrow, who seems very knowledgeable of CRPS, the treatment plan and modalities required. Provide history of injury to Fred and explained more than anything I feel the Employee and dtr are just uneducated on CRPS, feel that they have not rec'd the correct medical tx and are frustrated. Fred informed me he will take time with them tomorrow and explain CRPS and the treatment plan."

ERROR EXPLANATION: Now, we have NCM planting dx with PT rather than indicating bone scan did not support dx.

This is typical for CRPS cases where someone makes the diagnosis, without support in objective tests, and the diagnosis is then followed by everyone else.

NCM has made no assessment of whether the 8 factors noted for CRPS in Upper Extremity chapter of AMA Guides are present here. These factors are also factors for consideration in IASP diagnoses of CRPS and have not been considered by anyone here. She has also failed to ensure that necessary diagnostic tests are done and that criteria for diagnosis by IASP are met.

We now have nursing malpractice.

As a result, NCM has continued the incorrect diagnosis here, and Insurer should be responsible

for all TTD from date Dr. M found her P+S, any PD above Dr. M's findings, and all med treatment and physical therapy for CRPS.

5/27/10 **RED FLAG 9: CLMT'S DTR NOW WANTS DR. M WHOM SHE FOUND ONLINE.**

RED FLAG 10: HUGE RED FLAG!!!

Cmt's dtr writes NCM:

"Because of the doctors' irresponsibility my mom was left there without any care for five months. [This appears to relate to the fact that the Drs. G. dr did not see her for 5 months but, rather, a physician's assistant.]"

ERROR 16: THIS WAS A CLAIMS MANAGEMENT ERROR. CLAIMS ADJUSTOR SHOULD HAVE NOTED THAT CLMT WAS NOT BEING SEEN BY A DOCTOR FOR 5 MONTHS, WITH A DIAGNOSIS OF CRPS. THIS HAS EXACERBATED THE CLAIM. [MM]

"Maybe she got even worse by applying ice packs (some scientists say that this could cause more harm than good), or maybe her foot got worse because it was in the cast with inflammation."

5/28/10 **MEDICAL MALPRACTICE:**

PHYSICIAN ASST. "DR. P.A." PRESCRIBES NORTRIPTYLINE.

Clmt refuses to take it because, when she reads info, it says that it should not be taken by people with a family history of heart disease. Clmt will not take it because she might get heart complications. Both parents have heart pCl Ex 4lems. Father died at 47 from heart attack.
Mother has had 2 heart attacks and has high bp.

Clearly, this should have been discussed by "Dr. P.A." with the Claimant and her daughter.

ERROR 17: NURSE CASE MANAGER FAILS TO ADDRESS MED PRESCRIBED BY PHYS. ASST. [MM]

5/31/10 **PENALTY 1:** SIP OF 10% OF $101.67 FOR LATE PAYMENT OF TTD OF $1,016.74

6/4/10 Clmt's dtr advises NCM she chooses Dr. M based on her online research.

RED FLAG 11: CLMT'S DAUGHTER IS CLEARLY MANAGING THIS CASE BASED ON HER ONLINE RESEARCH.

6/8/10 Auth given by Insurer for Pain Management Tmt by Dr. M. **First appt avail: 7/12/10.**

ERROR 18: **This authorization should never have been given in absence of diagnosis of CRPS confirmed by diagnostic tests and physical findings. Further, Dr. M was chosen by Clmt's daughter online. Dr. M treated for years with no improvement. He notes that she failed rest, medication, physical therapy, and psychol. tmt. [MM]**

6/10/10 UR XXX indicates that Adjuster will request Transfer of Care to MPN as Dr. M not in MPN.

NCM ADVISES UR THAT DR. M IS IN MPN AND BILLS UNDER AN APPROVED TAXPAYER ID NUMBER.

6/22/10 Clmt seen by Dr. M for pain consult. Recommends two right sided lumbar sympathetic blocks and pain psychology consult. Both authorized.

NCM sends to Utilization Review on 6/28/10.

a. DX: RLE CRPS Type I, Chronic pain syndrome with both sleep and mood disorder

ERROR 19: **1. Is there any objective testing to support?**

NO

2. Are there any physical findings consistent with CRPS?

NO

[II, MM]

6/28/10 Dtr. notes that Clmt bought Clarks shoes. Clmt. has enormous pain while walking but also if she is sitting on the couch.

ERROR 20: At this point, surveillance should have been done in light of Clmt's contentions of enormous pain while walking. [II, E]

6/29/10 **RED FLAG 12: Dtr. wants pool therapy as she has read about it on internet.**

6/30/10 NCM HAS CONTACT WITH FRED, PHYSICAL THERAPIST:

Fred reports that Ee voices the same complaints over and over at every visit and seems to dwell on the fact that

the fracture was not diagnosed at the time of the injury and she was "left to suffer."

<u>RED FLAG 13</u>: EE FEELS DR. WAS IRRESPONSIBLE AND THAT SHE WAS "LEFT TO SUFFER."

Fred reports that EE has made some progress but that there are other things going on with the ankle. There was a significant sprain to the ankle as the Achilles tendon and fascia in the foot are very tight. Reports, without the CRPS, Ee would have a significant amount of pain.

<u>Perhaps the sprain is what has caused the pain. Interestingly, there is no mention of swelling, temperature differential, hair distortion, "bird taLn", or any of the physical findings usually associated with CRPS.</u>

<u>ERROR 21:</u> NCM should have picked up that there were no findings at physical therapy consistent with CRPS, including the 8 findings listed above and at p. 496 of AMA *Guides.* [I, E, MM]

Discussed hydrotherapy, per Fred, Ee has access to a pool at work, reportedly transportation is a problem as EE is unable to drive with the ankle pain. Fred reported that she would be able to perform exercises without fully bearing weight but hydrotherapy is not 'absolutely necessary."

7/2/10 Pain psychology eval is authorized. 6 sessions of psychotherapy authorized, and lumbar sympathetic blocks authorized.

8/3/10 Rpt. of Dr. M. She still has not had the lumbar sympathetic bLcks.

8/24/10 **Plan of action by Cl. Ex. Cl. Ex. 3:** **<u>GOOD.</u>**

1. Follow up with Dr. M for status of injections. (Not done. See note of 8/31/10. Holding off because she was making progress with PT.) **DONE.**

2. If no improvement within a few appts, object to tmt and begin PQME process. **DONE.**

3. When Clmt. is P+S, attempt to settle by CR. **DONE.**

8/31/10 Dr. M indicates to hold off with sympathetic block as she is making progress with the PT and they may not be necessary.

8/31/10 **<u>NURSING MALPRACTICE:</u>** Now, NCM does research on the internet on CRPS. (This should have been done long before she gave that diagnosis to the Physical Therapist.)

<u>ERROR 22</u>: **CONTINUING NURSING MALPRACTICE [I, E, MM]**

9/10/10 **SUPERVISORY <u>ERROR 23</u> BY KUUUUBERLY Y [I, E, SC]:**

"CRPS IS THE WORKING DIAGNOSIS BUT HAS NOT YET BEEN VERIFIED."

<u>That is absolutely correct. Verification should have been done. Yet, Ms. Y makes no request that the diagnosis be verified and, in fact, it has previously not been supported by bone scan and there continue to be no reported findings consistent with CRPS 8 factors.</u>

<u>DESPITE THAT, SHE THEN AUTHORIZES RESERVE INCREASE OF $63,724.87 *WITHOUT*</u>

VERIFICATION OF THE CONDITION.
[RESERVING ERROR]

INSURER IS NOW RESPONSIBLE FOR IMPACT ON EMPLYER X-MOD AS A RESULT OF THIS RESERVE INCREASE WITHOUT VERIFICATION.

9/27/10 Psych Eval. Psychologist Bb.

Dx: 1. Pain disorder assoc with both psychol fx and chronic pain; anxiety disorder

2. RLE CRPS Type 1, Chronic pain RLE

3. Stressors: Chron pain and ltd phys fxn pCl Ex 4ls with the healthcare system; lack of gainful employment, reduced vocational and social functioning

GAF = 55

Tmt rec: Pain mgmt and behav specialist for 6 visits. Auth. 9/30/10.

ERROR 24, 25: Sending the Clmt to see a Psych for eval without taking a statement from Clmt on psych issues and securing medical records is Claims Malpractice. Medical records showed lots of pCl Ex 4lems from war in Bosnia. This was claims malpractice and nursing malpractice. [I, E, MM]

10/14/10 File transferred to R V. (NCM)

10/25/10 Dr. M indicates he wants more PT.

PT is not certified as Clmt has had 30 sessions and inadeq. documentation provided.

K. R. indicates she will await determ from Cl. Ex as to whether he will object and go the QME route.

Axn: 1. Has Cl. Ex. decided to object and go QME route? YES. GOOD.

11/3/10 Cl. Superv K. H. tells JB. to obj to Dr. M and start QME process. **She indicates PQME process should be started. GOOD.**

Claims Superv H. notes that CRPS really hasn't been confirmed. She also notes that full Functional Restor Program is being discussed.

CORRECT. YET ERROR 26, 27: SUPERVISOR DOES NOT DO ANYTHING TO GET IT CONFIRMED, NOR DOES CLAIMS EXAMINER. [I, E, MM, SC]

Axn: 1. Does Cl. Superv H. folLw up? DOES NOT NEED TO. CL. EX. DOES IT. GOOD.

11/3/10 **Cl. Ex. Objects and requests PQME. GOOD.**

11/12/10 Cl. Superv notes that Cl. Examiner needs to be in contact with Clmt. **GOOD.**

12/12/10 Azra Last Name advises NCM that she got QME list. She has selected Dr. S. M with first avail appt on 1/27/11.

ERROR 26: It appears that Cl. Examiner has no record in file of having received ltr with 3 drs. names on it. No strike made. [I]

12/22/10 Cl. Ex. JB sends out PQME apt. notif ltr for Dr. M on 1/27/11.

1/10/11 Cl Ex 4. indicates that records should be sent to Dr. M. **GOOD.**

1/24/11 Med recs sent by overnight to Dr. M.

ERROR 27: **TIMELINESS. THESE RECORDS SHOULD HAVE BEEN SENT EARLIER THAN 3 DAYS BEFORE EVAL SO DR. M COULD REVIEW. [T]**

2/11/11 Pt. sees Dr. M. Panel QME.

Dx: CRPS, s/p right cuboid fracture--healed.

Allegedly given 9% WPI, no apportionment.

Allegedly, per note of 3/30/11, Dr. M includes CRPS in diagnosis but rates the impairment on station and gait disorder, not CRPS.

He allegedly finds 9% WPI.

ERROR 28: THERE IS NO 9% WPI UNDER THE STATION AND GAIT CHART AT TABLE 17-5, P. 529 OF THE *AMA GUIDES, FIFTH EDITION.* [E]

ERROR 29, 30, 31: AMA RATING INCORRECT. Cl. Ex. did not know it was incorrect. Cl. Ex. relied upon incorrect rating and failed to review AMA *Guides, Fifth Edition,* to see if it met the criteria. It did not.. [I, E]

1. Per p. 529, more specific method should be

used if available.

2. **Per p. 529: "An impairment rating due to a gait derangement should be supported by pathologic findings, such as x-rays."**

   a. **If diagnosis is cuboid fracture,**

3. **Per p. 529, Table 17-5, 7% WPI is given for an antalgic limp with a shortened stance phase and <u>documented moderate to advanced arthritic changes of hip, knee or ankle or advanced osteoarthritis of hip.</u>**

   Are there x-rays showing moderate to advanced arthitis of hip, knee, or ankle?

FMC: Care with podiatrist. PT x 2 per week for 3 wks

Clmt attorney wants CRPS and stip to 100%.

Plan of Action:

1. **Stop TD.**
2. **Start PD.**
3. **Settle FMC with clmt.**
4. **Close file in 90 days.**

<u>RESERVES SHOULD BE SET BASED UPON THIS. SEE 3/5/11.</u>

<u>THIS IS WHEN CASE SHOULD HAVE BEEN SETTLED. CLMT IS NOT REPRESENTED.</u>

2/7/11 AWW: $762.52; TTD: 508.37

2/7/11 **PQME M reports:**

1. Dx: CRPS; S/p right cuboid fracture--healed.

2. Work restr:

   a. No standing or walking over 15 min

   b. No lifting over 1-5 lbs

   c. No climbing over 2 flights of stairs at a time

3. Mmi: 2/7/11

Info on WPI redacted.

Tmt was apparently podiatrist and PT for 3 weeks.

<u>End of PT would be 2/28/10.</u>

2/11/11 Cl. Ex. calls EmpLyer, C MM.. Clmt stil out of work.
C did not know if they could accommodate modified
duty due to type of work.

<u>ERROR 32: CL. EX. NEVER EXPLAINS TO EMPLYER THE SIGNIFICANCE OF RETURNING CLMT TO WORK MODIFIED OR THE IMPACT ON THE AMOUNTS TO BE PAID. MAKES NO EFFORT TO HAVE EMPLYER ARRANGE MODIFIED WORK TO TAKE HER BACK. I HAVE A STRONG FEELING THIS WOULD HAVE REALLY HELPED RESOLVE THE CASE WITHOUT INTERVENTION OF AN ATTORNEY FOR EITHER SIDE. [E]</u>

2/11/11 Cl. Examiner calls Clmt. Notes that PD will be paid and TD

stopped. Offers $2,500 to settle future medical. **OK.**

SHOULD HAVE OFFERED MORE FOR FUTURE MEDICAL IN LIGHT OF THE HISTORY OF THIS CLAIM.

ERROR 33, 34:

1. **Offer for Fut Med is too low based on history of claim. [Settlement]**

2. **No dxn with Clmt re RTW. THIS IS A HUGE ERROR. [Settlement]**

2/11/11 NCM V closes her case as Clmt found P+S.

ERROR 35: 1. **NCM should have stayed on file until RTW issue resolved. [MM]**

3/5/11 Settl. Eval. Worksheet: **GOOD. [However, fails to note the rating is incorrect under AMA *Guides*.]**

ERROR 36: Settl. valuation based on incorrect rating. [Settlement]

Dr. M: 2/4/11:

Rating: 17.08.06.00 - 9 - [2] - 10 - 214 F - 10 - 13

Estimate value of PD: Def: 13% @ $265/wk = 11,175.

App. value of PD: App: 20% PD @ $265/wk = $19,970.00

Estim fut med: Def: $5,000. App: $15,000

Req. sett. auth: $20 - 25,000.

3/5/11 LARGE LSS RPT.

ERROR 37, 38: RESERVES BASED ON INCORRECT MED RPT. EXAMINER DID NOTHING TO GET REPORT CORRECTED SO THAT RESERVES COULD BE BASED ON CORRECT REPORT. [Settlement, Reserving, Investigation, Evaluation]

AWW: $762.52: TTD: $508.37

Clmt was TTD from 1/13/10 - 2/8/11 = $29,425.00.

P+S 2/7/11.

Er cannot accomodate mod duty. Clmt. is QIW.

Clmt. to be paid PD of 13.0% = $264.50 x 42.25 wks total $11,175.13. PD rate is 15% higher as insured has more than 50 EEs and cannot accomod mod duty.

Axn. Plan: 1. FU with App. for settl.

ERROR 39: CL. EX. DOES NOT DO THIS. [I, E, TOA]

2. If App does not want to settle, assign Def atty.

3. Obtain med tmt info if clmt continues tmt.

4. Attempt to settle by 5/11/11.

ERROR 40: Efforts by Cl. Examiner to settle this were completely inadequate. He low balls the Claimant with an offer of $2,500 for FMC. He then makes no proposal to Clmt's atty but, rather, asks

for a settlement demand. [Settlement]

3/18/11 Cl. Ex. is now contacted by Applicant's counsel.

ERROR 41: **CL. EXAMINER CL EX 4 J. DOES NO FOLLOW UP WITH CLMT RE SETTLEMENT. HE LOW BALLS HER ON SETTLEMENT PROPOSAL AND DOES NOT ADDRESS HER RTW. [Settlement]**

THIS CAUSED HER TO GET AN ATTORNEY. HIS ACTIONS CAUSED THAT. CASE SHOULD HAVE BEEN SETTLED BEFORE ANY ATTORNEY WAS INVOLVED. THEREFORE, FULL RESPONSIBILITY FOR AA FEES AND DEF ATTY FEES SHOULD LIE WITH FIRST COMP FOR TAKING INADEQUATE ACTIONS TO SETTLE THIS CASE WITH CLMT BEFORE SHE GOT AN ATTORNEY.

EmpLyer's responsibility should be the following:

5. Employer's responsibility should be the following:

   a. TTD from 1/13/10 - 2/7/11 @ $508.37/wk =
   391 days @ 72.63 = $28,398.33.

   b. PD of 13% PD = 42.25 weeks @ $230/wk =
   $9,717.50

   c. Fut Med: Tmt with podiatrist;
   PT 2 x / week x 3 weeks.

   Estim: $5,000

   d. Medical through **5/19/10** and then no med

for treatment of CRPS (pain mgmt or psych): 8,120.50

6. Cost of PQME Dr. M: (estimate) 2,000.00

7. Increase in PD if Clmt cannot RTW (See
PD rate increase to $264.50; however, Cl. Ex. never
explained to ER signif of mod work and never pushed ER on this.

As a result, Insurer responsible for increase
of $34.50 per week above $230/wk rate) =
0 attrib to Er.

8. Cost of rehab voucher:
(If awd less than 15% PD; $6,000
if awd between 15% and 25% PD)

4,000 - 6,000: Split: 5,000.00

9. Amt to settle (estimate) 25,000

TOTAL RESP OF EMPLOYER: $83,236.33

3/18/11 Cl. Examiner writes AA W W.:

Pain Mgmt not authorized per PQME. Please
select podiatrist.

Please send us settl proposal.

ERROR 42: **THIS IS A HUGE ERROR. YOU NEVER ASK THE AA FOR A SETTLEMENT DEMAND. CL. EXAMINER SHOULD HAVE**

ATTEMPTED TO SETTLE THE CASE AT THIS POINT BY PROPOSING SETTLEMENT. HE DID NOT. [Settlement]

ERROR 43: CASE SHOULD HAVE BEEN SETTLED AT THIS POINT AS WELL. [Settlement]

THIS IS ALSO A HUGE RED FLAG 14. ART JOHNSON IS A VERY EXPERIENCED AA AND OFTEN PURSUES 100% CASES.

ERROR 44: FAILURE TO SETTLE AT THIS POINT IS A HUGE ERROR IN LIGHT OF IDENTITY OF THE APPLICANT'S ATTORNEY. [Settlement]

AND, BIG SURPRISE, AA THEN REQUESTS STIP TO 100% PD ON 5/4/11.

3/22/11 Cl. Ex. speaks with C MM. who indicates they do not have modified work available.

ERROR 45: CL. EXAMINER DID NOT EXPLAIN THE IMPACT OF THIS ON THE EMPLYER AND THE POTENTIAL COST OF THIS. SIMPLY ACCEPTED IT AND SAID NOTHING. [Settlement]

THIS FAILURE INCREASED THE COST OF THIS CASE.

3/25/11 RESERVES NOW INCREASED FOR LITIGATION.

Reserves increased by $7,794.90 for new incurred of $96,613.62.

3/30/11 Cl. Superv T T. gives authority for $25,000.00 for settlement.

3/31/11 Patient seen by Dr. M **IN DR. A'S OFFICE.**. He indicates a Clmt is TD and in need of functional restoration program to regain function. He indicates that claim is "catastrophic."

<u>RED FLAG 15</u>: "CATASTROPHIC CLAIM."

3/31/11 Dr. M **<u>in Dr. A's office</u>** reports. He had been selected by Clmt dtr and approved by NCM.

1. "She was originally seen in an occupational medical clinic setting where x-rays were performed. Unfortunately, the x-rays were originally read as negative but then we found out later that a fracture was missed by the radiologist. It wasn't until she failed physical therapy and had an MRI that diagnosed the fracture." (p. 1)

2. "She was subsequently casted and during this process of casting had increased pain, swelling and the progressive inability to weight bear and progressive disability. When the cast was removed she had marked color changes, temperature changes, and edema in the affected extremity.

   [Please note:

   1. **No report of mottling or cyanotic color.**

   2. **No rpt that affected extremity was cooler than uninjured extremity. Further, there were actually <u>NO REPORTS OF TEMP CHANGES, BUT, RATHER, THAT COLD TEMPS AFFECTED HER SYMPTOMS.</u>**

      <u>There was no report of temperature differential.</u>

<u>ERROR 83</u>: NCM and Claims Examiner failed to pick this up. This is nursing and claims malpractice as the pt. does not meet the criteria for CRPS. [I, MM]

3. She had further diagnostic testing to include a bone scan. This ruled her out for having any further occult fracture, non-healing or non-union of the fracture of her foot." (p. 1)

[Please note: This also did not include any findings which verified dx of CRPS.]

<u>ERROR 84:</u> NCM and Claims Examiner failed to pick up that the test for CRPS was NEGATIVE, and Dr. M did not note this. [I, MM]

4. "She subsequently was seen by 2 different ortho and pain physicians who all agreed that she had a CRPS based on her physical examination mechanics of injury in her presentation. When I saw her, I felt that she was still in the early phases of the disease which is CRPS." (p. 1)

<u>As noted previously, the patient did not meet the criteria of IASP or AMA *Guides, Fifth Edition*, for diagnosis of CRPS.</u>

Essentially, Dr. M just repeated the incorrect diagnosis made by others in order to support the extensive treatment he provided, which did NOTHING.

5. The patient remained very afraid of any sympathetic blockade and did not want to undergo that type of operative procedure.

4/18/11 Cl. Ex. increases PD by 15% as Er cannot take EE back to work.

PENALTY 2 EXPOSURE: THIS SHOULD HAVE BEEN DONE ON 3/22/11. IT IS DONE NEARLY 1 MONTH LATER. PENALTY EXPOSURE = 25% OF PD.

ERROR 46: **[Timeliness]**

5/4/11 **AA REQUESTS STIP TO 100% PD.**

5/4/11 Cl. Ex. Cl Ex 4. seeks auth for referral to Def Atty.

Per eval by Dr. M on 2/4/11: Clmt is P+S. Allegedly given 9% WPI, no apportionment.

5/31/11 CL. EX. J. REQUESTS AUTHORITY FOR SURVEILLANCE. **GOOD.**

APPARENTLY, THIS IS PERFORMED.

6/20/11 Phone call from Def Atty Andrew L.

6/23/11 Plan of Action by Cl. Ex.

1. AA wants stip to 100%. Auth granted to $25,000.
2. FolLw up with DA re settlement or AME.
3. Fwd results of subro to DA by 7/11.
4. Settle claim by 10/11. **NOT DONE.**

6/23/11 Cl. Super authorizes either Dr. N. or Dr. S as an AME. Wants Def. Atty to pick.

ERROR 47: IN LIGHT OF RESULTS FROM AMES BY THIS DATE, USE OF AN AME IS INCORRECT DECISION. [I]

ERROR IS THAT DR. F N. IS A NEUROLGIST. THIS IS NOT THE SPECIALITY THAT DEALS WITH CRPS.

PLUS, HE IS AN AME. OF COURSE HE IS GOING TO SPLIT THE BABY IN HALF.

ERROR 48: FAILURE TO SHOW SUB ROSA FILMS TO AME [I, E]

THEN, DEFENDANTS DID NOT SHOW HIM THE SUB ROSA FILM WHICH SHOWED HER ABLE TO DO THINGS WHICH SHE HAD CONTENDED SHE COULD NOT DO.

6/24/11 DEF. AGREES TO DR. F N. AS AME.
Appt for 1/17/12.

7/14/11 **Surveillance conducted on 6/21/11 at Exped Hrg. Clmt walked with no apparent difficulty--no braces or supports were used. She walked 1 block to the WCAB with no visible limp or gait disturbance.**

GOOD.

FURTH SURVEILLANCE RECOMMENDED.

Axn: 1. Did Cl. Examiner implement?

ERROR 49: STILL HAS NOT BEEN DONE AS OF 9/22/11. [I, T]

Clmt's depo set for 8/10/11.

ERROR 50: SURVEILLANCE SHOULD HAVE BEEN DONE ON DEPO OF Q 8/10/11. [I]

7/28/11 Dr. M reports: "At this point the patient has failed outpatient rest, medicines, physical therapy and pain psychology." Now he wants Multidisciplinary eval to put together a comprehensive rehab plan consistent with MTUS guidelines.

RED FLAG 16: She has failed 4 types of tmt.

9/28/11 Records provided to DA of:

a. Medical Facility

b. Academy of Campbell

c. Academy of San Jose

10/11/11 Cl. Superv. finally approves 4 additional days of surveillance. Cl. Examiner has been recommending it be done at each appt. with Dr. M. **GOOD.**

ERROR 51: DELAY IN AUTHORIZING ADDITIONAL SURVEILLANCE. 1 DAY AUTHORIZED FOR DATE OF AME APPT WITH DR. N.. [T]

10/11/11 RESERVE INCREASE OF $21,714.69 FOR TOTAL INCURRED OF $120,328.31. ALL OF THIS IS DUE TO THE NEGLIGENT CLAIMS HANDLING BY INSURER.

10/12/11 One-day interdisciplinary eval. authorized.

ERROR 52: SHOULD HAVE DECLINED PENDING COMPLETION OF AME. [I, MM]

12/8/11 EDD Opening Lien: 2/9/11 @ $409.00/wk to $21,268.00

1/17/12 AME APPT. SCHEDULED.

Def. atty received Drs. G. records. Claimant has long history of psych issues, headaches, and trouble sleeping.

3/26/12 **<u>RPT OF AME N.</u>:**

17.08.06.00 - 31 = [2] - 35 - 214 F - 35 - 42% PD.

42.0% PD = 56,867.40

See 4/16/12:
1. Issues with rating of Dr. N.
2. Dr. N. did not see subrosa

4/4/12 Allegedly, Dr. N. says she should continue treating with Dr. M. Rpt of Dr. N. allegedly dated 3/26/12.

4/16/12 Note from Cl. Ex.:

1. Issues with rating of Dr. N.

<u>ERROR 53:</u> Rpt. of Dr. N. should have been sent to Expert Rater for Eval. [I, Litig Mgmt.]

2. Dr. N. did not see subrosa.

<u>ERROR 54:</u> Sub Rosa should have been sent to AME N. [I, Lit M]

Now they want to depose AME Dr. N..

4/16/12 LARGE LOSS REPORT.

1. Hrg set on 4/24/12 on issue of providing sub rosa to AME.
2. DA to set depo of AME., review ratings, and provide opinions. **NOT DONE TIMELY.**

<u>ERROR 55</u>: **[I, Lit M]**

AWW: $1,480.04

TTD rate: 986.69

Note: 1. On 4/15/10, Podiatrist P. notes possible CRPS due to little improvement and continuing pain.

2. Apparently, AME N. invoked *Almaraz/Guzman* and indicated Clmt was Gait Disorder Class II and gave 30% WPI.

<u>ERROR 56: This would be incorrect under *Almaraz II* and the AMA *Guides, Fifth Edition.*</u> **[E]**

Class II per Table 17-5, p. 529, would be 30% WPI if:

Patient required routine use of cane or crutch

AND

Short leg brace (AFO)

<u>INCORRECT:</u>

1. There is no prescription for cane or crutch.

2. There is no prescription for short leg brace.

3. This would not meet criteria of Table 17-5.

4. This would not meet criteria of *Almaraz II.*

5. *Almaraz II* is no Lnger the law of

California; *Guzman III* is which indicates that the strict AMA ratings are to be used except in exceptional and/or complex cases.

No indication AME N. has indicated Clmt falls in this class.

6. See note of 10/8/12: **No assistive devices being used. Therefore, this rating is incorrect.**

4/18/12 RESERVE INCREASE OF $78,759.03 BRINGING TOTAL INCURRED TO $199,087.34.

ERROR 57: RESERVE INCREASE BASED ON INCORRECT RATING. [R]

Dr. N. allegedly concurs with dx of CRPS.

Axn: 1. **Does this meet diagnostic criteria of AMA Guides or IASP?**

NO.

ERROR 58: Failure by Cl. Ex. and DA to address incorrect diagnosis. [I, LM]

Dr. N. recommends a psych evaluation.

Expert rating being sought of Dr. N.. **GOOD.**

ERROR 59: NOT SENT TO LESLIE AT IMPAIRMENT RATINGS UNTIL 7/16/12, 3 MONTHS LATER. CL. EX. WANTS IN 7 DAYS. [T]

LITIGATING ISSUE OF PROVIDING SUB ROSA FILMS TO DR. N. FOR REVIEW.

4/24/12 Hrg before Judge Challenged. Stips entered into:

1. Tmt auth with Dr. M based on serious and chron condition found by Drs. M and AME N..

2. Psychol consult auth within MPN.

3. **"Videos may be sent to AME Dr. N.. If Dr. N. wants reeval after viewing videos, that shall be arranged."**

ERROR 60: CLAIMS AND LEGAL MALPRACTICE. SUB ROSA VIDEO FILMS SHOULD HAVE BEEN SENT TO AME N. AT THIS TIME. [T, TOA]

5/14/12 Dr. N. reports: "Lastly, it is my understanding that there are some survillance videos that are to be sent for my review. I think it would make more sense for the parties to provide those videos to me in conjuction wih with Dr. K's AME psychiatry rpt and not beforehand. I presume Dr. K would consider the films."

ERROR 61: CLAIMS MALPRACTICE AND LEGAL MALPRACTICE

SUB ROSA VIDEOS SHOULD HAVE BEEN SENT TO DR. N. AT THIS TIME AS THEY ALLEGEDLY SHOWED CLMT DOING THINGS SHE TESTIFIED SHE COULD NOT DO. [I, TOA]

5/31/12 Dr. N. rpts. He indicates his prior rating was wrong. The 30% was LE, not WPI. Therefore, the correct rating is

12% WPI. He also noted that he did not follow the methodology on p. 350 regarding Ex. 13-47. **GOOD.**

He then indicated the 12% WPI is the "traditional" approach.

He withdrew the *Almaraz/Guzman II* ratings.

ERROR 62: RESERVES SHOULD HAVE BEEN REDUCED BASED ON THIS SUPPLEMENTAL REPORT TO REFLECT DR. N.'S NEW RATING OF 12% WPI.

NOT DONE. [R]

6/28/12 Psychol rpt by CLINIC 2:

1. p. 3: Clmt tries to walk 2 blocks per day.
   No report of use of cane or crutch. No rpt of use of short leg brace (AFO).

2. p. 2: She gets chiro treatment and PT for her shoulder which she rpts she pays for out of pocket.)

3. p. 4: POTENTIAL CLAIM OF POST TRAUMATIC STRESS DISORDER:

Ms. M rpts symptoms consist with anxiety related both to her current functioning and with possible post-traumatic stress disorder **due to her war exposure.**

1. Witnessed and experienced a range of traumatic events associated with the war in Bosnia.

2. During the war, her home was set on fire.

3. She and her husband hid their neighbors to save the neighbors' lives.

4. She lost her job and all her property.

5. She is "scarred" from the war and frequently feels " on edge and scared."

6. She has intrusive and upsetting memories about he war all the time and actively avoids any scenes related to war in movies or other media.

7. She states that her physical pain is similar to her war experiences, explaining that going through tmt and being involved in the work comp system feels similar to her time in the war.

DX: 1. Pain disorder assoc with both psychol fx and chron pain.

2. Anxiety Disorder NOS.

3. Sleep disorder due to chron pain, insomnia type

4. Rule out:

a) Depr disorder NOS;

b) PTSD

GAF: 50

Recommended tmt: EMDR for 8 sessions. (rapid eye movt)

<u>ERROR 63:</u> THIS SHOULD ALL HAVE BEEN BROUGHT OUT AT DEPO OF APPLICANT IN 8/11 AS SHE HAS RECEIVED PSYCHOL TMT. NO EVIDENCE IN NOTES THIS WAS BROUGHT OUT. [I, LIT MGMT]

7/16/12 Cl. Ex. finally sends to Impairment Ratings for rating.

ERROR 64: **Rpt. of Dr. N. should have been done by expert rater prior to depo of AME N.. [T]**

7/19/12 Dr. N. depo results:

1. Reversed opin on *Almaraz/Guzman.* **GOOD.**

2. Continues to believe AMA rating for gait derangement is appropriate.

ERROR 65: **DA should have had expert rating to use to question AME N. on this. [I, Lit M}**

Now there is an issue of retro TTD.

SUB ROSA FILMS STILL HAVE NOT BEEN SHOWN TO AME DR. N.

ERROR 66: **THIS IS CLAIMS MALPRACTICE. FILMS ALLEGEDLY SHOW DIFF. LEVEL OF ACTIVITY THAN CLMT CONTENDS. THESE SHOULD HAVE BEEN SHOWN TO DR. N. PRIOR TO HIS DEPO, UNLESS THERE WAS A COURT ORDER PREVENTING IT. [I, TOA, Lit M]**

7/26/12 EDD advised that they paid the following:

1. 2/9/11 - 1/3/12: Diff between their rate of $409 and $230 being paid by Insurer. Then picked up full benefit for period 11/16/11 - 7/12/12 at $409.00 per week.

8/21/12 Clmt. begins receiving SSDI benefits (Social Security Disability)

RED FLAG 17: **This is a red flag for a 100% case.**

8/24/12 Now Case is reviewed by Nurse for Addictive Drug Evaluation. Comprehensive Pharmacy Review requested. **GOOD.**

9/21/12 Supervisor KH. met with Wanda S. (agent/broker) and J. D. of HR with Employer).

1. IRating of Dr. N. was 14% WPI.

2. Current treatment: Functional Restoration Program.

ERROR 67: **AME N. should have been deposed re: results of indep rating. [I, Lit M]**

ERROR 68: **Functional Restoration Programs are incredibly inexpensive and rarely effective in Work Comp. EFFORTS SHOULD HAVE BEEN MADE TO SETTLE AT A HIGHER AMOUNT AT THIS TIME. NOT DONE. [Settl.]**

10/4/12 AA writes:

1. Per AME Dr. N. of 5/14/12, please pay TTD through 1/17/12.

Note: If not done by 10/18/12, penalty exposure 3.

2. Please advise if agree to Dr. Joshua K. as Psych AME.

3. If not, please consider Drs. Alberto Lopez, Allan Sidle, Lawrence Petrakis, Perry Segal, or James Bryant.

Axn: Did. A. Watts respond? NOT INCLUDED IN CLAIM NOTES.

10/5/12 AA requests auth for Lidoderm patches as AME Dr. N.

said appropriate.

<u>Note: If not done by 10/19/12, penalty exposure 4.</u>

10/8/12 Comprehensive Pharmacy Review: Practitioner Canady in Dr. M's office indicates that the use of hydrocodone has allowed the claimant to "be functional in activities of daily living (ADLs) without the use of assistive devices."

1. Lidocaine should be discontinued.

2. Hydrocodone with acetaminophen discontinued over 10 wks.

<u>Axn</u>: Was this done? CANNOT TELL FROM CLAIM NOTES.

10/12/12 Dr. M is to do the Functional Restoration Program. **<u>UNBELIEVABLE.</u>** Cl Ex 4ewell will not sign off on Dr. M's inflated fees. **<u>GOOD.</u>** [Note: None of Dr. M's other treatment has worked.]

11/13/12 No date set for Dr. N. Depo. Def. Atty also to find another doctor to do Functional Restoration Program.

<u>ERROR 69:</u> Depo of AME N. should have been set. [I, Lit M, TOA]

1/3/13 EXPEDITED HRG SET BY AA TO ADDRESS:

1. Retro TD from last date paid (2/8/11) though 1/17/12 (P+S date by Dr. N.) **Apparently not paid.**

<u>ERROR 70:</u> Failure to pay TTD after rcpt of rpt of AME N.. [TOA]

2. REDACTED

3. Penalties 5: Req benefits be brought current on 10/4/12 with no response from Defendants.

1/4/13 Now Clmt to be deposed on psych issues.

<u>ERROR 83:</u> SHOULD HAVE BEEN DONE AT PRIOR DEPO. [I, Lit M]

2/14/13 FRP still has not been done. Depo of AME N. still has not been done.

<u>ERRORS 70 AND 71:</u> NOT DONE [I, Lit M, MM, TOA]

2/22/13 Superv. K H requests that auth be granted for surveillance of 3 days. Clmt claims she has an altered gait and cannot drive. She has not been restricted from driving medically. **<u>GOOD.</u>**

<u>ERROR 72:</u> This should have been done months before. [SC, TOA]

2/22/13 Now, MSA is going to be needed for settlement.

2/25/13 Clmt to become Medicare eligible on 5/1/13.

CMS approval of settlement is approved if:

1) Medicare entitled with settlement over $25,000, or

2) Has applied for SSDI with app pending or is enrolled in SSDI or is 62.5 years old within 30 months of settlement YES

and settlement is over $250,000.

4/1/13 Clmt's depo set for this date. (Second depo)

ERROR 72: **This should have been done in 8/12 in light of findings on sub rosa. [I, Lit M]**

4/2/13 Now Applicant selects Dr. J L in San Jose as MPN provider.

4/3/13 Clmt receiving Soc Sec Disab since 8/21/12.

4/16/13 Dr. L reviewed portion of med records and will not accept Clmt. as patient.

RED FLAG 18: PHYSICIAN REFUSES TO TAKE CLMT.

4/23/13 Dr. N.'s depo set for this date. **HAS HE EVER BEEN SHOWN THE SUB ROSA. NOTE OF 4/10/13 INDICATES THAT NO USEFUL SUB ROSA WAS OBTAINED (THIS MUST BE THE SUBSEQUENT SUB ROSA).**

4/25/13 Total MSA amount: $63,027.49

5/15/13 Cl Ex 4. receives a copy of my email to Abram W. asking for status on case. **DOES NOTHING.**

ERROR 73: **FAILURE TO RESPOND TO REP OF EMPLYER PER LAB. CODE SECTION 3762. [I, Lit M, TOA]**

5/31/13 AME Dr. N. does supp rpt where he withdraws *Almaraz/ Guzman* until further discovery is complete. **GOOD.**

7/12/13 Dr. N. was deposed. Allegedly did not make any radical changes. Stated claimant would have class 1 gait impairment versus class II.

ERROR 74: GROSS CLAIMS MALPRACTICE AND ATTORNEY MALPRACTICE. SUB ROSA FILMS HAVE NEVER BEEN SHOWN TO DR. N.. FURTHER, IT IS UNCLEAR IF DEF ATTY IS ABLE TO DEPOSE DR. N. CORRECTLY AS THIS IS NOT A GAIT DERANGEMENT CASE. CRPS IS NOT RATED IN THAT WAY. [I, LIT M]

ERROR 75: LEGAL MALPRACTICE

NOW, THE CASE SHOULD HAVE BEEN SET FOR TRIAL WITH A MOTION TO STRIKE DR. N.'S REPORT AND TESTIMONY AS NOT SUBST MED EVID UNDER AMA GUIDES. [I, Lit M]

FAILURE TO SHOW DR. N. SUB ROSA FILMS IS CLAIMS AND LEGAL MALPRACTICE.

7/16/13 Def Atty has not provided summary of depo testimony of Dr. N. taken on 4/23/13.

ERROR 75: LEGAL MALPRACTICE AND CLAIM MALPRACTICE-- 3 MONTH DELAY IN GETTING SUMMARY OF DEPO [Lit M, SC]

Note that FRP completed by Claimant. No report on results. FR completed on 5/24/13

ERROR 76: No documentation of results of Functional Restoration Program. [Doc.]

7/22/13 Def atty is now going to forward FRP that was completed aLng with subrosa to AME for supplemental report.

ERROR 77: CLAIMS AND LEGAL MALPRACTICE

Sub rosa should have been sent to Dr. N. prior to his depo of 4/23/13. [Lit M, SC]

7/22/13 LARGE LOSS REPORT

1. DA to set depo of AME to get him to change severity of injury

2. "MD states PD would in fact be 12% which rates as folLws: 17.08.06.00 - 12 - [2] - 14 - 214 F - 14 - 18." This is AME N..

ERROR 78: **Reserves should have been reduced based on this. [R]**

10/16/13 Def atty received Drs. G. records. Appears that Clmt has long history of psych issues, trouble sleeping, and headaches.

ERROR 79: CLAIMS AND LEGAL MALPRACTICE

THESE RECORDS SHOULD HAVE BEEN SECURED AND REVIEWED AT THE TIME THAT PSYCH ISSUES WERE RAISED, FROM CLMT'S FIRST DEPO, AND PRIOR TO HER BEING SEEN BY EITHER THE PSYCHOLGIST OR AME DR. N..
[T]

ERROR 80: AME OPINES TMT SHOULD BE WITH DR. IN PAIN MANAGEMENT.

THIS REINFORCES THE ERROR IN SELECTING A NEUROLGIST, DR. N., AS AN AME IN A CONDITION WHICH IS NORMALLY TREATED BY

EITHER A RHEUMATOLGIST OR A PAIN MANAGEMENT SPECIALIST.

[I, Lit M]

AA sought panel in Psych. Panel received on 10/16/13.

AA has stated interest in *Ogilvie* issue.

MASSIVE RED FLAG 19 FOR 100% PD

ERROR 81: THIS REINFORCES THE CLAIMS AND LEGAL MALPRACTICE IN NOT HAVING AME DR. N. SEE THE SUB ROSA FILMS WHEN YOU ARE FACING A 100% PD FINDING PER *OGILVIE*. [I, TOA]

10/31/13 Clmt. allegedly did complete FRP. FRP recommended ongoing participation; clmt declined due to non-industrial issues. Cl Ex. has no ideas what those are.

ERROR 82: Cl. Ex. needs to find out what the non-industrial issues are. [I, TOA]

Psych panel QME is Dr. F.

10/31/13 RESERVE INCREASE OF $68,799.46 BRINGING TOTAL INCURRED TO $267,886.80

Reeval with Dr. N. to be scheduled.

11/8/13 **LAST CLAIM NOTE. CASE NOT YET RESOLVED.**

Discussion of Overpayments:

The causes of the overpayments are more fully discussed below.

1. Authorization of treatment for CRPS from 4/16/10 is incorrect as bone scan did not support diagnosis nor were othe necessary tests for diagnosis (x-ray, temp measurement with infrared therm) and physical findings shown.

    a. Therefore, Insurer was negligent in this authorization.

    b. Insurer failed to review Dr. Hadler's book which indicates that bone scan is the gold standard for diagnosis of this condition.

    c. Further, Clmt's condition did not meet the 8 diagnostic criteria of RSD. Insurer failed to review IASP criteria for diagnosis or AMA *Guides, Fifth Edition,* criteria.

    d. **All med treatment for CRPS from 5/19/10 is the responsibility of Insurer.**

2. Supervisory error: Error of C P. to simply refer to pages in AMA Guides and not provide guidance as to whether or not this met diagnostic criteria for CRPS. (5/21/10).

3. Nursing malpractice by NCM:

5/27/10 NCM has conversation with Physical Therapist at Star PT.

ERROR 3: Nurse Case Manager C. tells Physical Therapist Clmt has CRPS. This is completely incorrect as the bone scan did not support the diagnosis.

We are now in potential medical malpractice area. NCM is diagnosing CRPS when it is not supported by bone scan results.

POTENTIAL NURSING MALPRACTICE

NCM WRITES:

"Lengthy conversation with Fred, the therapist that EE is scheduled with for tomorrow, who seems very knowledgeable of CRPS, the treatment plan and modalities required. Provide history of injury to Fred and explained more than anything I feel the Employee and dtr are just uneducated on CRPS, feel that they have not rec'd the correct medical tx and are frustrated. Fred informed me he will take time with them tomorrow and explain CRPS and the treatment plan."

ERROR EXPLANATION: Now, we have NCM planting dx with PT rather than indicating bone scan did not support dx.

This is typical for CRPS cases where someone makes the diagnosis, without support in objective tests, and the diagnosis is then followed by everyone else.

NCM has made no assessment of whether the 8 factors noted for CRPS in Upper Extremity chapter of AMA Guides are present here. These factors are also factors for consideration in IASP diagnoses of CRPS and have not been considered by anyone here.

We now have nursing malpractice.

Insurer should be responsible for all TTD from date Dr. M found her P+S, any PD above Dr. M's findings, and all med treatment and physical therapy for CRPS.

4. Insurer is responsible for impact on EMPLYER x-mod by reserve

increases above **$83,236.33** in absence of verification of diagnosis of CRPS.

.

5. Employer's responsibility should be the following:

1. TTD from 1/13/10 - 2/7/11 @ $508.37/wk = 391 days @ 72.63 = $28,398.33.

2. PD of 13% PD = 42.25 weeks @ $230/wk = $9,717.50

3. Fut Med: Tmt with podiatrist; PT 2 x / week x 3 weeks.

   Estim: $5,000

4. Medical through **5/19/10** and then no med for treatment of CRPS (pain mgmt or psych)

Summary of Med Tmt through 5/19/10:

1/12/10	307.30
1/12/10	170.00
1/13/10	307.30
1/13/10	39.00
1/13/10	440.00
1/20/10	137.30
1/27/10	182.30
1/27/10	345.00
2/3/10	230.00
2/4/10	120.00

2/10/10	220.00	
2/18/10	665.00	
2/18/10	230.00	
2/24/10	182.30	
3/3/10	452.30	
3/23/10	91.00	
3/24/10	182.30	
4/12/10	509.17	
4/15/10	91.00	
4/15/10	40.00	
4/15/10	182.30	
4/16/10	1967.00	Bone Scan
4/16/10	125.	
4/19/10	230.	
4/21/10	182.30	
4/30/10	127.	
5/5/10	137.30	
5/14/10	228.33	
5/14/10	39.00	

TOTAL: $8,120.50

5. Cost of PQME Dr. M: (estim) 2,000

6. Increase in PD if Clmt cannot RTW (See
   PD rate increase to $264.50; however,
   Cl. Ex. never folLwed up with ER
   about mod work after Er said unsure.
   Insurer responsible for increase
   of $34.50 per week above $230/wk rate) =

   0 attrib to Er.

7. Cost of rehab voucher:
   (If awd less than 15% PD; $6,000
   if awd between 15% and 25% PD)

   4,000 - 6,000: Split: 5,000.00

8. TOTAL:

a.	TTD:	28,398.33
b.	PPD:	9,717.50
c.	Fut med:	5,000.00
d.	Rehab Voucher:	5,000.00
		$48,115.83
e.	Amt to settle	25,000.00

TOTAL VALUE:

Everything beyond that should be the responsibility of Insurer.

f. Med Exp. thru 5/19/10: 8,120.50

TOTAL RESP OF EMPLYER: $83,236.33

6. Concern: Further negligent claims handling will result in a 100% PTD case.

7. Case should have been settled 3/5/11. If so, then Clmt would not have been receiving SSDI benefits (started 8/21/12) and MSA would not have been needed in settlement. DOB: 12/16/51: At of 3/5/11, she was 59 years old and would not be Medicare eligible within 30 months--elig age 65. She become 65 on 12/16/16. As of 3/5/11, she was not within 30 months (i.e. 2.5 years) of medicare eligibility as she was 59 years old.) Note: MSA was $63,027.00 for FMC and prescriptions.

8. NCM's directing this case to Dr. A. made the situation worse.

9. The treatment by Dr. M did nothing. No effort was made to push to get this treatment discontinued. Dr. M himself noted that she failed rest, PT, medication, and pain psychology. None of these are effective for treatment of CRPS. Therefore, the treatment was ineffective as not appropriate for the condition.

10. There are no medical reports which detail the classic findings of CRPS. Dr. A contends that, when the cast was removed after casting for the cuboid fracture, the patient had edema, color changes, and temperature changes. There is no report that any of these findings continued after the evaluation by Dr. A.

WHAT NEEDS TO BE DONE NOW:

1. Sub rosa film needs to be forwarded to Dr. N. (AME) for review. Dr. N. does not have the right to say he will not review them until Dr. K. has reviewed them.

2. Further sub rosa needs to be implemented, 24 hours a day for a 5 days, if necessary, to avoid the 100% finding.

3. Apparently, Psych PQME F is doing the psych eval.

4. Eval needs to be authorized by Dr. K as AME N. has now boxed Defendants in on the need to have Dr. K evaluate the Applicant and review the sub rosa films.

Reservation

Note--the materials provided by CIGA may not be complete, and some of the issues may require additional review and assessment. Therefore, this report is being provided as a draft, and pending further evaluation and discovery, some of my opinions and conclusions may change.

ATTACHMENTS:

TRAUMA UPDATE

Early Diagnosis in Post-traumatic Complex Regional Pain Syndrome

Georg Gradl, MD; Oliver Rommel, MD

- **Orthopedics**
- **June 2007 - Volume 30 · Issue 6**
  - **ARTICLE**

Complex regional pain syndrome is characterized by the presence of regional pain and sensory changes folLwing a predominantly traumatic noxious event.

Complex regional pain syndrome is a severe complication in orthopedic surgery. Trauma patients as well as patients undergoing orthopedic procedures frequently deveLp complex regional pain syndrome, particularly after lesions of the hand or forearm. It is characterized by the presence of regional pain and sensory changes folLwing a predominantly traumatic noxious event. Pain is associated

with abnormal skin coLr, skin temperature changes, abnormal sudomotor activity, and edema. Two types of complex regional pain syndrome can be distinguished: type I, formerly termed “reflex sympathetic dystrophy,” occurs without a definable nerve lesion, whereas type II, formerly termed “causalgia,” refers to cases where a definable nerve lesion is present.[1]

The diagnosis of complex regional pain syndrome is predominantly based on clinical signs and symptoms. Various laboratory tests or imaging procedures have been applied in complex regional pain syndrome. However, the majority of tests have not been evaluated with regard to their sensitivity (ie, the pCl Ex 4ability that a patient having complex regional pain syndrome will have a positive test result) and specificity (ie, the pCl Ex 4ability that a patient without complex regional pain syndrome will have a negative test result). No consensus exists on the criteria to diagnose complex regional pain syndrome or reflex sympathetic dystrophy and even with the new definitions of complex regional pain syndrome, inteCl Ex 4server reliability and specifity is still poor and depends on the criteria used.[2-4]

Another important limitation is a consequence of the progressive nature of complex regional pain syndrome. In early stages, edema and increased skin temperature may be observed, whereas in later stages signs of autonomic dysregulation decrease but pain may persist. Diagnostic tests useful in early stages of the disease eventually may fail. Furthermore, signs and symptoms may change quickly. As a result, in many studies correlations between clinical findings, stage of the disease, and laboratory tests are not reported. Combined, these limitations impede the determination of the diagnostic value of different test procedures used in complex regional pain syndrome.

Nevertheless, it is important to establish an early diagnosis if it appears after trauma or surgery. This article presents an overview of the clinical implications of tests and procedures in diagnosing complex regional pain syndrome.

Clinical Signs and Symptoms

Since complex regional pain syndrome is a clinical diagnosis, the appearance of a typical constellation of symptoms is fundamental for establishing the diagnosis. In 1995 the definition of complex regional pain syndrome was re-evaluated by a Consensus Committee. A few years later, advanced diagnostic criteria were published to facilitate the clinical diagnosis.[1,2] The criteria of clinical symptoms are shown in Tables 1 and 2.

Tests to Verify Clinical Findings

Inter-rater reliability is poor in the clinical diagnosis of complex regional pain syndrome and clinical signs may be difficult to evaluate; laboratory tests are helpful to verify the diagnosis. A hand volumeter can be used to determine edema by measuring the fluid overfLw displaced by water comparing the healthy and diseased limb (Figure 1).[5]

With motor disturbances, a goniometer is necessary to assess active or passive range of motion of joints. A dynamometer and hand function questionnaires (eg, disability of arm, shoulder, hand or the Michigan hand questionnaire) can register the degree of disability due to reduced hand function.[6,7] Measurements of pain intensity can be performed using a visual analog scale.[8]

Figure 1: Clinical findings of post traumatic complex regional pain syndrome I of the left hand.

The assessment of temperature side differences in complex regional pain syndrome is mandatory for establishing the diagnosis and can be detected with an infrared thermometer at different measuring points or with infrared thermal imaging. However, the dynamic character of this phenomenon (depending on disease duration and environmental factors) should be taken into account.

While in healthy patients only slight differences in skin temperature between sides have been documented (hands, 0.24±0.23°C; fingers, 0.43±0.26°C), in patients after hand or wrist trauma without any complication side differences of 0.9°C±0.8°C were reported up to 8 weeks after trauma.[9,10] In patients with complex regional pain syndrome, side-to-side temperature differences of 0.5°C, 0.6°C, or 1°C have been observed indicating high statistical variation and substantial overlap with trauma patients lacking complex regional pain syndrome: a useful diagnostic threshold should be set at a side difference of 1.5°C to differentiate between normal physiological post-traumatic states and complex regional pain syndrome I.[11-13]

Other clinical findings include sensory impairment that can be subdivided into “positive” (ie, alLdynia, mechanical, and thermal hyperalgesia) and “negative” (ie, hypesthesia, hypalgesia) sensory findings and has been observed in a Lcalized (ie, gLve-like) and generalized (ie, upper quadrant, hemisensory) distribution.[14]

Quantitative sensory testing to confirm the clinical findings of sensory abnormalities was applied; however, the findings were not specific for complex regional pain syndrome and do not deliver relevant additional diagnostic information. This method is not recommended as a routine laboratory test for the diagnosis of complex regional pain syndrome.

Sympathetic Function Tests

Numerous studies revealed evidence for malfunction of the sympathetic nervous system in patients with complex regional pain syndrome. Since the interpretation of these findings is controversial, the existence of sympathetic disturbances, particularly in the early phase of complex regional pain syndrome, is unquestionable. This phenomenon can be assessed in several ways, leading to different diagnostic procedures with various physiological approaches.

The peripheral vasoconstrictor reflex, mediated by -adrenergic sympathetic fibers, can be assessed by laser Doppler flowmetry or thermography using different stimuli (whole body warming, arousal maneuvers). To evaluate sweating, qualitative methods exist that visualize the sweat response, or indirect methods like the registration of skin potentials (sympathetic skin response) can be applied.[15] Alternatively, sweat output can be quantified by evaporative measurement. Local sweating can be induced through an axon reflex (quantitative sudomotor axon reflex testing, peripheral stimulation). The resting sweat output as well as the sweating induced by raised body temperature (thermoregulatory sweating, thermoregulatory sweat testing, central stimulation) can be recorded.[16-18]

While vasoconstrictor activity is lowered in complex regional pain syndrome, sudomotor function is either unaltered (resting sweat output) or enhanced (thermoregulatory sweat testing, quantitative sudomotor axon reflex testing). Laboratory tests described are a useful diagnostic tool for complex regional pain syndrome; however, these tests are difficult to conduct and none could reach clinical importance due to the lack of standardization and practicality.[19]

Neurophysiological Tests

The diagnosis of complex regional pain syndrome type I excludes–by definition– the presence of peripheral nerve lesion and therefore nerve conduction veLcity abnormalities are not expected. However, the diagnosis of complex regional pain syndrome type II requires a peripheral nerve lesion and complex regional pain syndrome may develop following central nervous lesions, eg, brain infarction or brain tumors. Since signs and symptoms of complex regional pain syndrome I and II may be very similar, neurophysiological testing is important in differential diagnosis of complex regional pain syndrome to confirm or to exclude major

peripheral nerve or central nervous system damage.

With respect to nerve conduction velocity testing, discrete abnormalities on nerve conduction velocity testing may be observed due to edema or peripheral vasoconstriction.[15,20] Distinct abnormalities >20% of normal values should be noted and may indicate underlying peripheral nerve lesion, eg, carpal tunnel syndrome or complex regional pain syndrome II. Electromyography recordings were not routinely applied in clinical studies in complex regional pain syndrome patients because electromyography is painful and may worsen complex regional pain syndrome.

With respect to somatosensory-evoked potentials after median/ulnar or tibial nerve stimulation in complex regional pain syndrome I patients, somatosensory-evoked potentials reveal normal results in the majority of patients and in few patients borderline delay of latencies or amplitudes. In patients with suspected complex regional pain syndrome II (severe trauma, localized sensory, or motor abnormalities consistent with peripheral nerve or radicular distribution) somatosensory-evoked potentials may be pathological. Particularly in complex regional pain syndrome II due to proximal nerve lesions and in patients with possible central nervous system pathology, somatosensory-evoked potentials may be helpful, as proximal nerve or central nervous system lesions cannot be detected with routine nerve conduction velocity measurements.

In complex regional pain syndrome patients with signs of central nervous system dysfunction, eg, hemisensory deficits or dystonia, somatosensory-evoked potentials recordings may be useful. Normal results indicate that the abnormalities may be due to functional neuroplastic changes and further diagnostic procedures (ie, magnetic resonance imaging [MRI] of the brain or spinal cord, lumbar puncture) are only required if the clinical picture reveals structural central nervous system lesions.[14]

Neurophysiological tests are useful in the differential diagnosis of complex regional pain syndrome I and II to confirm a peripheral nerve or central nervous system lesion; however, the findings are not specific for the disease.

Assessment of Inflammatory Parameters

As first described by Sudeck,[27] clinical symptoms of complex regional pain syndrome reveal similarities to an inflammatory reaction. Within the past few years, several studies on arterial blood flow, oxygen utilization and lactate flux in complex regional pain syndrome as well as spectroscopic and scintigraphic studies were conducted that supported the hypothesis that an exaggerated inflammatory response may play an important role for complex regional pain syndrome. However, the laboratory abnormalities observed in these studies were

not pathognomonic for complex regional pain syndrome. Thus the tests applied were predominantly of scientific interest.

For clinical purposes, it is important to distinguish complex regional pain syndrome from a local limb infection (ie, osteomyelitis, erysipel) that may have similar clinical findings. Laboratory tests in complex regional pain syndrome show parameters that mediate a systemic inflammatory response (C-reactive protein, erythrocyte sedimentation rate, leukocyte count) are not elevated in complex regional pain syndrome whereas neuroinflammatory mediators like substance P, bradykinin, and calcitonin gene-related peptide were increased compared to healthy controls. This finding also supports the assumption of a localized inflammatory response that might be triggered by neurogenic mechanism. For differential diagnosis, this important finding points out that in patients with symptoms of complex regional pain syndrome but increased findings of generalized inflammation (erythrocyte sedimentation rate, C-reactive protein, and leukocytes increased), other causes of inflammation should be excluded (Table 3).[21-23]

PsychoLgical Assessment

With respect to psychopathology, no compelling evidence exists that complex regional pain syndrome is a psychogenic condition or that certain personality traits predispose one to develop complex regional pain syndrome.[24,25] In different studies, an increased frequency of anxiety and mood disorders has been reported.[26] However, compared to patients with other chronic pain disorders (headache, back pain, neuropathic pain), no evidence exists that complex regional pain syndrome patients display more psychological distress than other chronic pain patients

Therefore, psychological abnormalities are not pathognomonic but may precede, accompany, or be a consequence of complex regional pain syndrome. Recommendations for the use of psychological questionnaires should follow the general guidelines of the Psychiatric and Psychological Societies and should be adapted to the clinical picture.

Imaging Methods

Radiography

Figure 2: Radiological findings of complex regional pain syndrome of the left hand.

Since Sudeck[27] described the typical radiographic changes on plain radiographs of the affected extremities, conventional bilateral radiographs of the hand are standard for diagnosing complex regional pain syndrome. The primary radiographic manifestations are diffuse osteoporosis with a severe patchy demineralization, especially of the periarticular regions, combined with a subperiostal bone resorption (Figure 2). In the middle of the past century, several authors noted evidence of a radiographic progression paralleled to the clinical disease activity.[28,29] Later, typical radiological findings in complex regional pain syndrome patients were supposed to be unspecific and to appear late during the course of the disease. Prospective studies about particular findings and their clinical relevance are rare.

Bickerstaff et al,[30] who investigated radiographic changes in patients after Colles' fracture with and without complex regional pain syndrome interpreted the similarity of disuse demineralization and complex regional pain syndrome, related demineralization as an effect of a common pathogenesis. They found a more marked and proLnged bone Lss in complex regional pain syndrome patients compared to immobilized trauma patients. This bone Lss occurs more markedly at trabecular bone but increased endosteal resorption of cortical bone is also a feature. The extreme Lss of function in complex regional pain syndrome patients may accelerate the bone demineralization process.

By applying a semi-quantitative scoring system for classifying the demineralization findings in 274 patients with Colles' fracture a positive predictive value of 83% was reported 7 weeks after trauma (sensitivity 87%, specificity 75%). The scoring system consisted of a combination of features that are apparent at sites of trabecular bone. These comprise a generalized Lss of density, patchy radiotranslucencies, subchondral radiotranslucencies, and a Lss of trabecular definition.[31] Our findings could not confirm these results in a study with similar design and radioLgical examiners who were blinded towards the clinical findings of the patients. This investigation yielded a high specificity of radioLgical findings 8 weeks after trauma, but a fair sensitivity of 36%, leading to a positive predictive value of 58% in 175 patients after distal radial fracture. This data showed a high number of patients with clinical symptoms of complex regional pain syndrome that did not expose the typical radioLgical findings. The underlined assumption is that radiographic changes appear late during the course of the disease and that radiography does not qualify as a screening procedure.[32]

Three-phase Bone Scan

Figure 3: Three-phase bone scan in complex regional pain syndrome of the left hand.

Three-phase bone scans have been used for three decades to diagnose complex regional pain syndrome. In particular, Kozin et al[29,33,34] established the characteristic pattern of scintigraphic findings that are present in complex regional pain syndrome patients. Accelerated bLod fLw into the affected limb combined with an increased diffuse activity during the bLod pool phase and an increased periarticular uptake in the delayed static phase are supposed to be pathognomonic for complex regional pain syndrome (Figure 3).[35] According to changes in the clinical picture during the course of the disease, the scintigraphic pattern is subjected to changes that should provide useful information about therapeutic effects.[36]

Most of the published studies present data about retrospectively analyzed patient populations that underwent three-phase bone scan examination.[37,38] Diffusely increased juxta-articular tracer activity on delayed images was found to be the most sensitive indicator for complex regional pain syndrome. In these studies only patients with clinical suspicion for complex regional pain syndrome were examined; their results are limited due to bias in patient selection. The prevalence of complex regional pain syndrome in the aforementioned study populations did not reflect the actual incidence of the disease in an unselected post-traumatic patient population.[39]

Prospective studies describing the diagnostic power of three-phase bone scan in complex regional pain syndrome are rare. Todorovic et al[40] investigated complex regional pain syndrome patients after trauma using three-phase bone scan and radiography and found a high sensitivity with a positive predictive value of 97% in delayed bone scintigrams, whereas the radiography reached a sensitivity of 73% and a positive predictive value of 90%. These results must be carefully interpreted because only patients with clinical suspicion for complex regional pain syndrome were examined (n=20). The control group consisted of one patient.

Bickerstaff et al[32] compared 16 patients with post-fracture complex regional pain syndrome to 6 patients with normal fracture healing and found significantly elevated periarticular uptake in the complex regional pain syndrome patients. In our recent study 175 patients after distal radial fracture were prospectively folLwed for 4 months and three-phase bone scan was performed twice. Two blinded observers detected signs for complex regional pain syndrome in only

16% of the clinically diagnosed complex regional pain syndrome patients 8 weeks after trauma. In contrast to the Lw sensitivity, a high specificity was found in the same study.

A meta-analysis of 19 articles relating three-phase bone scan to complex regional pain syndrome in the upper extremity also revealed a poor sensitivity of approximately 50% of this diagnostic method. The sensitivity of three-phase bone scan decreases with the duration of the disease.[39,41] This observation suggests that in later stages of the disease the characteristic changes in soft tissue and bone that lead to the pathoLgical scintigraphic findings normalize and are replaced by a centralization of the symptoms.

Three-phase bone scan appears to be a good diagnostic tool in non-trauma patients. For the early differentiation of normal post-traumatic states and complex regional pain syndromes, this diagnostic method does not offer sufficient accuracy.

Magnetic Resonance Imaging

Since MRI alLws visualization of soft-tissue and bone structure with high resolution, it has become an important tool in diagnosing various muscuLskeletal disorders. Several authors suggested its application for diagnosing complex regional pain syndrome I.

Magnetic resonance imaging examination in complex regional pain syndrome I patients revealed various findings that change during the course of the disease in a characteristic manner.[42] Skin thickening and bone signal intensity changes in carpal and metacarpal bones as well as effusions of adjacent joints are supposed to be related to the acute and early phase of complex regional pain syndrome I.[43,44]

Magnetic resonance imaging is commonly performed with T1- and T2-weighted sequences and T1-weighted sequences with fat suppression before and after intravenous administration of contrast material (gadolinium-DTPA). Koch et al[45] questioned the diagnostic value of MRI in diagnosing complex regional pain syndrome, since they found among 17 clinically diagnosed complex regional pain syndrome I patients only 1 patient with typical MRI findings. Our data obtained in MRI investigation in 175 patients 8 and 16 weeks after distal radial fracture revealed a poor sensitivity of MRI that decreased from the 8th week to the 16th week investigation (43% to 14%) and a high specificity of 78% in the 8th week to 98% in the 16th week investigation. These results suggest that the consequences of trauma or surgery mimic complex regional pain syndrome I-like MRI findings. In the early phase of complex regional pain syndrome disease patients often present without typical MRI findings. Thus MRI is not a useful

screening method, but may be helpful in the exclusion of differential diagnoses.

Summary

Since prospective studies confirmed an incidence of >10% of complex regional pain syndrome complication in patients after distal radial fracture, early diagnosis is important.[32,46] Therapy should be commenced immediately with a systematic approach to avoid chronicity of the disease. Despite this, epidemioLgical studies revealed an extreme delay in effective treatment among complex regional pain syndrome patients, who were repeatedly referred to different physicians and often treated inadequately before being referred to specialized pain clinics.[47]

In post-traumatic patients, the clinical examination still is preferred to establish the diagnosis of complex regional pain syndrome. First, possible differential diagnoses must be excluded. Next the clinical criteria of the consensus definition should be checked and documented, if possible with the help of verifying procedures. Imaging methods could be applied; however, they are not useful for early diagnosis since sensitivity is Lw and the consequences of trauma may interfere with potential complex regional pain syndrome findings. In questionable cases repeated examinations after short periods detect the presence of complex regional pain syndrome in orthopedic patients, particularly if symptoms are progressive or an expected improvement does not occur.

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